

## Report of the Inspector of Mental Health Services 2008

<b>HSE AREA</b>	HSE Dublin North East
<b>CATCHMENT</b>	Cavan/Monaghan
<b>MENTAL HEALTH SERVICE</b>	Cavan/Monaghan
<b>APPROVED CENTRE</b>	St. Davnet's Hospital
<b>NUMBER OF UNITS OR WARDS</b>	3
<b>UNITS OR WARDS INSPECTED</b>	Ward 15 Admission Ward 4 Ward 8
<b>NUMBER OF RESIDENTS WHO CAN BE ACCOMODATED</b>	36
<b>CONDITIONS ATTACHED TO REGISTRATION</b>	No
<b>TYPE OF INSPECTION</b>	Unannounced
<b>DATE OF INSPECTION</b>	27 August 2008

### **PART ONE: QUALITY OF CARE AND TREATMENT SECTION 51 (1)(b)(i) MENTAL HEALTH ACT 2001**

#### **INTRODUCTION**

In 2008, there was a focus on continuous quality improvement across the Mental Health Service. The Inspectorate was keen to highlight improvements and initiatives carried out in the past year and track progress on the implementation of recommendations made in 2007. Information was gathered from service user questionnaires, staff interviews and photographic evidence collected on the day of the inspection.

#### **DESCRIPTION**

St. Davnet's Hospital continued to operate three wards within the approved centre, though the bed capacity had been reduced since the last inspection. There was an admission unit and two psychiatry of later life continuing care wards.

<b>WARD</b>	<b>NUMBER OF BEDS</b>	<b>NUMBER OF RESIDENTS</b>	<b>TEAM RESPONSIBLE</b>
Ward 15 (Admission Unit)	11	7	Monaghan CMHT Community rehabilitation team
Ward 4 (Female)	15	15	Psychiatry of later life team Rehabilitation team
Ward 8 (Male)	10	10	Psychiatry of later life team Rehabilitation team

**Ward 15:** On the day of inspection there were seven residents, five male and two female. Five residents were detained under the Mental Health Act 2001. The bed capacity was 11. Two teams had admitting rights to the unit. The psychiatry of later life team had admitting rights to the admission unit in Cavan. On the day of inspection the unit was locked. There were five nursing staff on duty during the day and four at night.

**Ward 8:** On the day of inspection, there were 10 male residents in this continuing care unit. The majority of residents were under the care of the psychiatry of later life team, the others were under the care of the rehabilitation team. The bed numbers had reduced since the last inspection. The Inspectorate was informed that there were plans to upgrade this unit and merge it with Ward 4.

**Ward 4:** On the day of inspection, there were 15 female residents in this continuing care unit. The majority of residents were under the care of the psychiatry of later life team, the others were under the care of the rehabilitation team.

## **RECOMMENDATIONS ARISING FROM THE 2007 APPROVED CENTRE REPORT**

*1. There should be a therapeutic activities programme on each ward.*

**Outcome:** A new occupational therapist had commenced working in the service. Programmes were available on each unit but they did not link into the residents individual care plan.

*2. All building works and refurbishment of wards should be completed as soon as possible.*

**Outcome:** There were improvements on Ward 15, a new shower room and female toilet had been installed. However the male toilet was unsatisfactory. There were no improvements on Ward 4 or Ward 8.

*3. The single bedroom in Ward 15 should be decommissioned, as it was not suitable for use as a bedroom.*

**Outcome:** This room was no longer used as a bedroom.

## **MDT CARE PLANS 2008**

Multidisciplinary team (MDT) care plans were in place. The system ensured that goals were set with the resident and reviewed by the MDT. The resident did not attend team meetings but could attend a ward round facilitated by the medical and nursing staff. The resident was not given the opportunity to sign their care plan and was not given a copy.

## **GOOD PRACTICE DEVELOPMENTS 2008**

- The number of beds in the long-stay wards continue to decrease and the move to amalgamate the two wards with appropriate refurbishment was welcome.

## **SERVICE USER INTERVIEWS**

A number of residents spoke to the Inspectorate and they were all content with their standard of care.

## **2008 AREAS FOR DEVELOPMENT ON THE QUALITY, CARE AND TREATMENT MENTAL HEALTH ACT 2001 SECTION 51 (b)(i)**

1. Ward 15 should have a garden area that is safe and secure to increase the opportunities for residents to access fresh air.
2. The plans to upgrade Wards 4 and Ward 8 must be implemented as the condition of these wards continues to deteriorate.
3. The male toilets must be upgraded on Ward 15.

## **PART TWO: EVIDENCE OF COMPLIANCE WITH REGULATIONS, RULES AND CODES OF PRACTICE, AND SECTION 60, MHA 2001**

In 2008, the inspection focused on areas of non-compliance identified in 2007. In addition, the Inspectorate re-inspected compliance with all the Articles in Part Three of the Regulations (15–21 and 26) and the Rules and the Codes of Practice in each approved centre. In 2008, two new Codes of Practice were issued and compliance with them was inspected. Where conditions were attached, they were inspected in detail. Evidence of compliance was established through three strands:

- Inspection of compliance where there was a breach in 2007. This was cross-referenced with the action plan submitted to the MHC Standards and Quality Assurance Division.
- Written evidence requested prior to the inspection, for example policies.
- Evidence gathered during the course of the inspection from staff, service users, photographic evidence and photocopies.

### **2.1 EVIDENCE OF COMPLIANCE WITH CONDITIONS ATTACHED TO REGISTRATION**

As no conditions were attached, this was not applicable.

### **2.2 EVIDENCE OF COMPLIANCE WITH REGULATIONS UNDER MENTAL HEALTH ACT 2001 SECTION 52 (d) ON 27 AUGUST 2008**

#### **Article 15: Individual Care Plan**

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An overarching care plan was used, with all disciplines contributing to it. Each resident on Ward 15 was reviewed at the twice-weekly general adult team meeting. The resident did not attend this meeting but could access the weekly ward round facilitated by the medical and nursing staff. Residents were not given the opportunity to sign their care plan and did not receive a copy of it. On the elderly care wards, individual care plans were implemented and reviewed by the psychiatry of later life team.

**Compliant:** Yes

#### **Article 16: Therapeutic Services and Programmes**

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No structured activity or therapeutic programme in accordance with the residents' care plan was in place on the acute admission wards. On the long-stay wards, a programme had been drafted by the psychiatry of later life team. The service had employed an occupational therapist and programmes were available on each ward. However the occupational therapist provided input to all three wards and to the admission unit in Cavan. This resource was insufficient to meet the needs of the residents and hindered the development of programmes linked to individual care plans.

**Breach:** The residents did not have access to an appropriate range of therapeutic services and programmes in accordance with their individual care plans. The programmes available on the ward were not linked to individual care plans.

**Compliant:** No

#### **Article 17: Children's Education**

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On the day of the inspection, it was reported that St. Davnet's Hospital had not had any children admitted since 1 November 2006.

**Compliant:** Not applicable

### **Article 18: Transfer of Residents**

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The service was compliant with this Article.

**Compliant:** Yes

### **Article 19 (1-2): General Health**

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On the acute admission ward, the NCHD completed a full physical examination on admission. On Ward 4 and Ward 8, a GP completed all physical examinations and attended the wards daily. All physical examinations had been completed within the last six months. All residents had access to the flu vaccine and a record was kept of when it had been administered. A procedure was in place for responding to medical emergencies on all wards.

**Compliant:** Yes

### **Article 20 (1-2): Provision of Information to Residents**

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The Inspectorate was informed that the information booklet was being printed and would be forwarded to the Inspectorate when available. This had been made available.

**Compliant:** Yes

### **Article 21: Privacy**

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The service was compliant with this Article.

**Compliant:** Yes

### **Article 22: Premises**

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In general, the approved centre was clean and bright and well maintained. However, a number of outstanding issues remaining from last year's report had not been addressed. The bathroom and female toilet on Ward 15 had been upgraded to a high standard, but the male toilets were in need of upgrading. Despite the best efforts of the cleaning staff, who should be commended for the high standard of cleanliness in the wards, the male toilets had an unpleasant smell and appeared to be in a poor state of repair. There had been no developments on Wards 4 and Ward 8 despite assurances last year. The Inspectorate was informed that there were plans to upgrade these units and combine them into one ward. Plans for this were forwarded to the Inspectorate.

**Breach:** Ward 4 and Ward 8 were in need of an upgrade.

**Compliant:** No

### **Article 26: Staffing**

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The number of staff and skill mix of staff was appropriate to the needs of the residents. It was noted that on the day of inspection there were five qualified nurses on duty for seven residents. An occupational therapist had commenced a service to the wards but his time was spread thinly around each of the wards in the catchment.

Ward staff, ward attendants and domestic staff were on duty daily. The director of nursing or the assistant director of nursing was in charge of the centre. Education and training was available to the general adult teams, rehabilitation team and psychiatry of later life team. All staff had completed the training in the Mental Health Act 2001 and the Regulations and Rules were available on the ward on the day of the inspection.

**Compliant:** Yes

**Article 28: Register of Residents**

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The service was compliant with this Article.

**Compliant:** Yes

## 2.3 EVIDENCE OF COMPLIANCE WITH RULES – MENTAL HEALTH ACT 2001 SECTION 52 (d)

### SECLUSION

There were no seclusion facilities in the approved centre and staff reported that seclusion was not used. There was a written statement in the service policy to verify this.

**Compliant:** Not applicable

### ECT

The service did not have ECT facilities. Any residents who required ECT were transferred to another service.

**Compliant:** Not applicable

### MECHANICAL RESTRAINT

One resident had been prescribed mechanical means of bodily restraint.

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Rules for the Use of Mechanical Restraint.

SECTION	DESCRIPTION	COMPLIANCE REPORT
14	Orders	Non-compliant. There was no evidence that the reasons for restraint were given to the resident, or why this was the case. There was no evidence that the resident's next of kin were informed of the need to use mechanical restraint.
15	Patient dignity and safety	Compliant
16	Ending mechanical restraint	Compliant
17	Recording use of mechanical restraint	Non-compliant. Not all episodes of mechanical restraint were recorded in the clinical file.
18	Clinical governance	Non-compliant. A policy on mechanical restraint was provided which stated that only Part 5 was in operation. However one resident had required mechanical restraint which was not covered under Part 5.
19	Staff training	Compliant
20	Child patients	Not applicable
21	Part 5: Use of mechanical means of bodily restraint for enduring self-harming behaviour	See Section 18 (Clinical governance) above.

**Breach:** Section 14, Section 17, and Section 18.

**Compliant:** No

## 2.4 EVIDENCE OF COMPLIANCE WITH CODES OF PRACTICE – MENTAL HEALTH ACT 2001 SECTION 51 (iii)

### PHYSICAL RESTRAINT

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Physical restraint practice forms had only been in operation since June 2008. There was no record of use of any physical restraint prior to this date. Therefore it was not possible to inspect all Sections of this Code of Practice.

The following table provides a summary of the Inspectorate's findings in relation to compliance with the Code of Practice for the Use of Physical Restraint.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	Orders	Not applicable
3	Resident dignity and safety	Not applicable
4	Ending physical restraint	Not applicable
5	Recording use of physical restraint	Compliant. Physical restraint practice forms had only been in operation since June 2008. There was no record of use of any physical restraint between June 2008 and the date of inspection.
6	Clinical governance	Compliant. There was a policy on physical restraint.
7	Staff training	Compliant. Three nursing staff were trained in management of aggression and violence.
8	Child residents	Not applicable

**Compliant:** Yes

### ADMISSION OF CHILDREN

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It was stated in policy that children were not admitted to this centre.

**Compliant:** Not applicable

## NOTIFICATION OF DEATHS AND INCIDENT REPORTING

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The following table provides a summary of the Inspectorate's findings in relation to compliance with the Code of Practice for the Notification of Deaths and Incident Reporting.

SECTION	DESCRIPTION	COMPLIANCE REPORT
2	Notification of deaths	Compliant.
3	Incident reporting	Compliant. Reporting systems were in place and were coordinated by the ADON and CNM2.
4	Clinical governance	Compliant. Statistics of incidents were collated each year. There was no formal audit carried out within the centre. There was no risk management committee that involves staff of the mental health service. Risk management policies were available.

**Compliant:** Yes

## ECT FOR VOLUNTARY PATIENTS

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The service did not have ECT facilities. Any residents who required this were transferred to another service.

**Compliant:** Not applicable

**2.5 EVIDENCE OF COMPLIANCE WITH SECTIONS 60/61 MENTAL HEALTH ACT (MEDICATION)**

There was no resident who met the criteria on the day of inspection.

**Compliant:** Not applicable